for covered ancillary services rendered during the reporting period. The total of the interim payments made by the Program in the reporting year is computed. The difference between the reimbursement due and the payments made shall be the amount of retroactive adjustment.

D. ANCILLARY SERVICES. Upon receipt of the facility's cost report, the Department shall as expeditiously as possible analyze the report and thereafter commence any necessary audit of the report. Following receipt and analysis of any audit findings pertaining to the report, the Department shall furnish the facility a written notice of amount of Program reimbursement. The notice shall (1) explain the Department's determination of total Program reimbursement due the facility for the reporting period covered by the cost report or amended cost report; (2) relate this determination to the facility's claimed total reimbursable costs for this period; and (3) explain the amount(s) and the reason(s) for the determination through appropriate reference to Program policy and procedures and the principles of reimbursement. This determination may differ from the facility's claim.

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The Department's determination as contained in a notice of amount of Program reimbursement shall constitute the basis for making the retroactive adjustment to any Program payments for ancillary services made to the facility during the period to which the determination applies, including the suspending of further payments to the facility in order to recover, or to aid in the recovery of, any overpayment determined to have been made to the facility.

E. ROUTINE SERVICES. When a retroactive adjustment is made to the routine rate the Fiscal Agent shall adjust all routine payments made based on the rate which was adjusted.

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119. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID PATIENTS

A. PRINCIPLE. When a patient is eligible for medical coverage under both the Title XVIII (Medicare) Program and the Title XIX (Medicaid) Program, the facility participates in both programs, and a day of care is a Medicare covered day, the patient shall be considered to be a Medicare patient for purposes of this reimbursement system.

B. APPLICATION. Services received by a patient which are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Nursing Facility Cost-Related Payment System in a manner prescribed by the Program. Such co-insurance and deductible payments shall be based on rates set by the Medicare Program. A day of service covered in this manner shall be considered a Medicare patient day and shall not be included as a KMAP patient day in the facility cost report.

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120. RETURN ON EQUITY OF PROPRIETARY PROVIDERS

An allowance for a return on equity capital invested and used in the provision of patient care shall not be allowed. In lieu of a return on equity the Program provides the Cost Savings Incentive factor.

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121. DESK REVIEW AND FIELD AUDIT FUNCTION

After the facility has submitted the annual cost report, the Division of Reimbursement Operations shall perform an initial "desk review" of the report. During the desk review process, program staff shall subject the submitted Cost Report to various tests for clerical accuracy and reasonableness. If the Program detects clerical error, the Program shall return the submitted Cost Report to the provider for correction. If Program staff suspect possible errors other than simple clerical errors, the Program staff shall require the provider to submit supporting documentation to clarify any areas brought into question during the desk review. The desk review shall not be deemed to be completed until all clerical errors have been rectified and all questions asked of the provider during the desk review process have been answered fully. Additionally, results of this desk review shall be used to determine whether a field audit, if any, to be performed. The desk review and field audits shall be conducted for purposes of verifying prior year cost to be used in setting prospective rates and in adjusting prospective rates which have been set based on unaudited data. Ancillary service cost shall be subject to the same desk review and field audit procedure to settle prior year costs.

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The field audit procedures shall include an audit of Patient Fund Accounts to insure the Program that the providers are in compliance with appropriate federal and state regulations.

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122. REIMBURSEMENT REVIEW

Participating facilities are provided the following mechanism for a review of Program decisions relating to the application of the policies and procedures governing the Case Mix Assessment Reimbursement system.

A. A facility may request reconsideration of a Program decision by writing to the Director, Division of Reimbursement Operations. The provider shall insure that the request is received by the Program within 45 days following transmittal of the audited cost report to the facility or the notification of their prospective rate. The request for workpapers pertaining to audit adjustments to the facility's cost report shall not extend the 45 day time limit. The request for appeal shall indicate which adjustments the facility wishes to appeal. A blanket request to appeal the cost report shall not be accepted. Upon receipt of the request for review, the Division shall determine the need for a Program/Vendor conference and shall contact the facility to arrange a conference if needed. The conference, if needed, shall be held within 60 days of the Program's receipt of the facility's request for review unless delayed due to extenuating circumstances. Regardless of

the Program decision, the provider shall be afforded the opportunity for a conference if the provider desires a full explanation of the factors involved and the Program decision. Following review of the matter, the Director shall notify the facility of the action to be taken by the Division within 20 days of receipt of the request for review or the date of the Program/Vendor conference, except that additional time may be taken as necessary to secure further information or clarification pertinent to the resolution of the issue.

B. If the Director of Reimbursement Operations' decision is unsatisfactory, the facility may then appeal the question to a Reimbursement Review Panel established by the Commissioner of the Department for Medicaid Services which shall include the Director of the Division of Reimbursement Operations (or a designee), a representative of the Kentucky Association of Health Care Facilities, and the Commissioner or the Director of the Division of Program Development and Budget (or designee) who shall serve as chairperson.

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The request for review by the Reimbursement Review Panel shall be postmarked within 20 days following the notification of the initial decision by the Director, Division of Reimbursement Operations. A date for the Reimbursement Review Panel to convene shall be established within 20 days after receipt of a written request for such appeal. The question shall be heard by the Panel. The Panel shall issue a binding decision on the issue within 30 days of the hearing of the issue, except that additional time may be taken as necessary to secure further information or clarification pertinent to the resolution of the issue. In carrying out the intent and purposes of the program the Panel may take into consideration extenuating circumstances which must be considered in order to provide for equitable treatment and reimbursement of the provider.

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COMMONWEALTH OF KENTUCKY

Cabinet for Human Resources

Department for Medicaid Services

KENTUCKY MEDICAL ASSISTANCE PROGRAM

NURSING FACILITY PAYMENT SYSTEM

PART II

NURSING ASSESSMENT